



DEPARTMENT OF HUMAN SERVICES
SENIOR & DISABLED SERVICES DIVISION
500 Summer Street NE
Salem, Oregon 97310-1015
Phone: (503) 945-5811

AUTHORIZED BY: _____

**SDSD Administrator/Deputy/
Assistant Administrator**

INFORMATION MEMORANDUM

SDSD-IM-01-056

Date: June 14, 2001

TO: SDSD District and Unit Managers
AAA Directors

SUBJECT: Department of Human Services Criminal Records Unit & SDSD Provider
& Consumer Services Unit

INFORMATION: Effective June 20, 2001, Senior and Disabled Services Division staff involved in processing criminal history checks will be moved to the newly formed Department of Human Services Criminal Records Unit. The unit will be supervised by Georgena Carrow (503) 378-8973. Their new address and phone numbers are:

Criminal Records Unit
2850 Broadway NE #100
Salem, Oregon 97303

In-Watts Line: 1-888-272-5545
Main Line: (503) 378-5470
Fax: (505) 378-2588

Attached are copies of all the criminal history forms. They have been revised to reflect the above changes. Field office staff are to continue requesting criminal history checks using the criminal history check application, often referred to as "macros." Field office staff should contact Margie Bibby (503) 945-6836 for the latest version which will direct the requests for criminal history checks to the new unit.

SDSD's provider enrollment and provider payment staff will remain at the Executive House located at 325 13th St. N.E., Salem, Oregon 97310 (P.O. Box 14960, Salem, 97309-5045). The process for requesting provider numbers, adjustments, CBC late pays and forced payments has not changed; however, updated versions of the "macros" should be obtained by contacting Margie Bibby (503) 945-6836.

As a result of the criminal history unit staff moving out of the Executive House combined criminal history check/provider number requests cannot be processed. Criminal history clearance checks must be processed first by the Criminal Records Unit. A request should then be made to the Provider & Consumer Services Unit for a provider number.

CONTACT PERSONS:

Provider Enrollment/Provider Payments: Joan Larson (503) 378-2563

Updated Version of Criminal History Check Application: Margie Bibby (503) 945-6836

Attachments

Criminal History Clearance Release Authorization

APD/ADR COMPLETES	<div>1 Type or print name of APD/ADR, organization and mailing address</div> <div></div>	2 Telephone number ()	FAX number ()
		3 Provider type <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Adult Foster Home <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Relative Foster Home <input type="checkbox"/> Residential Care Facility <input type="checkbox"/> Other (<i>specify</i>) <input type="checkbox"/> In-Home	
		4 Signature of APD/ADR Date Signed	

APD/ADR MAY NOT BE A FAMILY MEMBER OF APPLICANT

I have read and understand **both sides** of this form. I authorize SDSD to conduct a criminal history check on me. I am providing complete and accurate information. I authorize SDSD to release information to the authorized provider designee (APD) or authorized Division representative (ADR) listed above. I understand that submission of my social security number is voluntary (**READ** instructions on back of this form).

APPLICANT COMPLETES THIS SECTION	5 Applicant's Last Name	First Name	Middle Name	6 Date of Birth	7 Race	8 Sex	9 Social Security Number - -
	10 Maiden Name	11 Other Last Names Used				12 Driver's License Information Number: State:	
	13 Current Mailing Address			14 Home Phone Number ()		15 Position Applied For	
	16a Have you ever been convicted of any crime in Oregon or any other state? <input type="checkbox"/> Yes. List crime(s), date(s) of conviction, city and state. Also complete the Mitigating Information form (SDS 303B). <input type="checkbox"/> No. <div>Attach additional page(s) if necessary.</div>						
	16b List any arrest in Oregon during the past 5 years that did not result in a conviction. For each arrest: List date, charge(s), city, and charge status (pending, dropped or dismissed). <div>Attach additional page(s) if necessary.</div>						
	16c List any arrest outside of Oregon, regardless of when it happened, that did not result in a conviction. For each arrest: List date, charge(s), city and state, and charge status (pending, dropped or dismissed). <div>Attach additional page(s) if necessary.</div>						
	17 Have you lived outside of Oregon for 60 or more continuous days during the last three years? <input type="checkbox"/> Yes <input type="checkbox"/> No						
WARNING: Misleading or false information may result in disqualification. Authorization valid for 12 months from date signed.							
18 Signature of Applicant						19 Date Signed	

SDSD USE ONLY	20 SDSD Use Only (DO NOT WRITE IN THIS SPACE) <input type="checkbox"/> Fit (No disqualifying Oregon history. No fingerprints required.) <input type="checkbox"/> Potentially Disqualified (APD/ADR must make fitness determination.): <input type="checkbox"/> 5 year <input type="checkbox"/> Permanent <input type="checkbox"/> Discrepancy/False or misleading information <input type="checkbox"/> Disposition Unknown (APD/ADR must discuss with applicant and make fitness determination.) <input type="checkbox"/> Fingerprints on file: <input type="checkbox"/> Awaiting FBI results <input type="checkbox"/> See attached letter <input type="checkbox"/> Fingerprints required (Submit only if applicant is currently employed or being considered for work, training, or volunteering.): <input type="checkbox"/> Out-of-state residence <input type="checkbox"/> Multi-state offender (303B required) <input type="checkbox"/> Self disclosure (303B required) <input type="checkbox"/> Other: _____	Reviewer Initials Date Issued <div>PLEASE REMIT:</div>
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Instructions for Applicant

Purpose. This form should only be used by people who work, volunteer, train or receive training in a nursing facility, residential care facility, assisted living facility or adult foster home; client-employed providers; and employees of in-home agencies who provide services to SDSD clients.

Complete boxes 5-17. If you do not provide the requested information or if you do not tell the truth, you may be disqualified. Failure to provide your social security number will not be used as a basis to deny you any right, benefit or privilege provided by law. If you choose not to provide your social security number, fingerprint cards will be required.

Box 7, Race. W=Caucasian, B=African American, A=Asian or Pacific Islander, H=Hispanic, I=Native American or Alaskan

Boxes 18 & 19, Sign and Date form. Signing this form authorizes SDSD or an authorized vendor to obtain information about you from the **Oregon State Police, Federal Bureau of Investigation (FBI)** and **other law enforcement agencies and courts**. It also allows SDSD to recheck your criminal history during your employment.

Return the SDS 303 form.

- Client-employed providers and adult foster home providers return this form to your local SDSD/AAA office.
- All others return the form to the facility or agency that asked you to complete it.

Criminal history checks for long term care providers are required by law pursuant to ORS 181.537.

Instructions for Employer, Agency or Facility


Complete boxes 1-4.

When to Submit Fingerprint Cards. Submit fingerprint cards only if “Fingerprints required” is checked in box 20 and the applicant is currently employed or being considered for work, training or volunteering. Fingerprinting can be completed by local or state law enforcement agencies and private vendors. There is usually a charge for fingerprinting. In addition, the Oregon State Police and FBI charge for processing the prints.

Returning the Form. Nursing facilities, residential care facilities, assisted living facilities, and agencies contracting with the Division should FAX the completed form to (503) 378-2588 or mail it to Department of Human Services, Criminal Records Unit, 2850 Broadway NE #100, Salem, OR 97303.

Criminal History Clearance Mitigating Information & Fitness Determination

This form must be completed by any person who checked "Yes" in Box 16a on the SDS 303 form .

1 Name of Applicant		2 Name of Facility, Agency, Employer, Training Institution	
<div>3 List each crime of which you have been convicted. Explain the details concerning each crime. Also include date and location (city and state).</div> <div style="text-align: right; margin-top: 20px;"><input type="checkbox"/> Continued on Attached Page(s)</div>			
<div>4 Describe your history following the above crime(s). Explain what you have done that demonstrates you have learned from your past and are not likely to commit similar crimes in the future.</div> <div style="text-align: right; margin-top: 20px;"><input type="checkbox"/> Continued on Attached Page(s)</div>			
5 Have you ever been accused of abuse, domestic violence or neglect? If "yes," provide explanation.			
APPLICANT'S SIGNATURE 		6 Signature of Applicant	
Date Signed			
7 Preliminary Determination <input type="checkbox"/> Fit <input type="checkbox"/> Probationary <input type="checkbox"/> Wait for FBI Check <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>		8 Final Fitness Determination <input type="checkbox"/> Fit <input type="checkbox"/> Unfit (Oregon Check) <input type="checkbox"/> Unfit (National Check) <div style="text-align: center; margin-top: 10px;">CIRCLE: 5-YEAR PERMANENT DISCREPANCY</div>	
Name of APD/ADR		9 FBI Check <i>SDSD USE ONLY</i> <input type="checkbox"/> No FBI History <input type="checkbox"/> No Disqualifying FBI History <input type="checkbox"/> FBI/Fit <input type="checkbox"/> FBI/Unfit	
Date of Preliminary Determination		10 Name of APD/ADR	
Date of Final Determination		11 APD/ADR Signature	
		12 Date Signed	

Instructions for Completing SDS 303B

Box 3. If you answered “Yes” in Box 16a on the Criminal History Release Authorization form (SDS 303), you must list **all convictions** in any state regardless of when they occurred. *Failure to disclose your criminal history may result in disqualification.*

Box 4. Explain what you have done that demonstrates you have learned from your past and are not likely to commit similar crimes in the future. The following are examples of what **you may submit**:

- A statement of what you did to change your life
- Certificates or records showing what counseling or programs you are/were in, how long you were in them and the type of treatment
- Letters from counselors and parole or probation officers
- Performance evaluations or written statements from employers
- Written character references from individuals fully aware of your past
- Any other documents.

Hearing Rights

INSTRUCTIONS FOR APPLICANT:

Right to a hearing. If you have been found “unfit” to work, volunteer or train in long term care based on Oregon’s Criminal History Clearance rules (OAR Chapter 411, Division 009), you may request a hearing. You have the right to have a copy of the SDS 303, SDS 303B or any supplemental form.

How to request a hearing. Complete an Administrative Hearing Request form (AFS 443) and return within 45 days from the date of notice of the fitness determination. The AFS 443 can be obtained from your local SDSD office or by calling 1-888-272-5545. You have the right to seek legal assistance.

Where to return the hearing request form.

If the fitness determination was based on your Oregon criminal history and the determination was made by your local SDSD/AAA office, a long term care facility, an in-home agency, a school, a hospital or an employment office, return the AFS 443 to the facility or agency who gave it to you.

If the fitness determination was based on your FBI criminal history and the determination was made by the Department of Human Services Criminal Records Unit, return the AFS 443 to the Criminal Records Unit at 2850 Broadway NE #100, Salem, OR 97303.

INSTRUCTIONS FOR SDSD/AAA OFFICES, AGENCIES AND FACILITIES:

Where to return the hearing request form (AFS 443).

Local SDSD/AAA offices: If your office made the fitness determination, return the AFS 443 directly to the Hearing Officer Panel. If the Criminal Records Unit made the fitness determination (based on FBI history), return the form to Criminal Records Unit, 2850 Broadway NE #100, Salem, OR 97303.

All other agencies or facilities: Return the form to Criminal Records Unit at the address above.

Criminal History Clearance
Authorized Provider Designee (APD)/
Authorized Division Representative (ADR) Application

I, _____ (print/type name), request to be an APD or ADR for the facility or agency listed below. I will not divulge LEDS criminal history to anyone other than the applicant or another APD/ADR. I understand Senior and Disabled Services Division (SDSD) will conduct a criminal history check on me (fingerprint cards required) and authorize them to do so. I understand that submission of my social security number is voluntary and that failure to provide it will not be used as a basis to deny me any right, benefit or privilege provided by law.

1 APD/ADR Last Name First Middle			2 Date of Birth Mo: Day: Yr:		3 Social Security Number - -	
4 Maiden Name <i>(If applicable)</i>			5 Other Names Used			
7 Mother's Maiden Name <i>(Used to confirm identity)</i>			8 Driver's License Information NUMBER: STATE:			
9 Home Mailing Address CITY STATE ZIP CODE						
10 Sex <input type="checkbox"/> M <input type="checkbox"/> F		11 Day Phone ()		12 Signature Date Signed		
<i>By signing this application, I certify I have no criminal history</i>						
13 Facility/Agency/Branch Name & Address Phone Number: ()			14 Facility/Provider /Agency Type <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> Nursing Facility <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Residential Care Facility</div><div><input type="checkbox"/> SDSD/AAA Branch <input type="checkbox"/> In-Home Services Agency <input type="checkbox"/> Other, specify:</div></div>			
15 Name/Title of Appointing Authority <i>(Print)</i>			16 Signature of Appointing Authority		17 Date Signed	
DIVISION USE ONLY						
18 Preliminary Determination (Pending FBI check) <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> Approved <input type="checkbox"/> Disapproved</div></div>			20 Final Determination (FBI results) <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> Approved <input type="checkbox"/> Disapproved</div></div>			
19 Processed By		Date		21 Processed By		
				Date		

Instructions for Applicant

Please carefully print or type all requested information (Boxes 1-12).

This form is for appointing Authorized Provider Designees from:

- ☐ Nursing Facilities
- ☐ Residential Care Facilities
- ☐ Assisted Living Facilities
- ☐ In-Home Care Agencies and other entities which contract with Senior and Disabled Services (SDSD) to provide services in the homes of SDSD clients

And for appointing Authorized Division Representatives from local offices representing Senior and Disabled Services Division.

You must be free of all criminal history in order to be accepted as an “authorized provider designee.” Conviction of any crime eliminates the possibility for approval.

You are not required to include your social security number on this form. If you include your social security number, however, it may help to expedite the process and help ensure your history is not confused with someone else’s.

Mail this form, two completed fingerprint cards, and a \$12 check payable to **Department of Human Services, Criminal Records Unit, 2850 Broadway NE #100, Salem, OR 97303**.

By signing this form, you agree to never disclose any criminal history information obtained through the Law Enforcement Data System (LEDS) unless specifically authorized to do so pursuant to ORS Chapter 257. You agree to keep such information confidential.

An authorized provider designee may serve more than one facility. Be certain to identify the name of each facility you are serving.

Family Members. The authorized provider designee shall not initiate a criminal history check, have access to information obtained through the check, or participate in a fitness determination, if the caregiver is a family member of the designee. Family member includes: husband, wife, natural parent, child, sibling, adopted child, adoptive parent, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, aunt, uncle, niece, nephew and first cousin.

Instructions for Facility/Agency

The appointing authority (Nursing facility administrator, residential care facility administrator, assisted living facility administrator, in-home services agency manager or local Senior Services branch manager) completes Boxes 13-17.